

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 3, 14, Film G224 1-3-58 et
13171
CERTIFICATE OF DEATH

13169

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			
c. LENGTH OF STAY IN TB <u>2 hrs 15 min</u>				d. STREET ADDRESS <u>328 Law St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Hubert</u> Last <u>Alder</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 March 1903</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>		11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Switzerland</u>							
13. FATHER'S NAME <u>Charles Alder</u>				14. MOTHER'S MAIDEN NAME <u>Louise Kunz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213 38 9111</u>		17. INFORMANT <u>Mina Alder (wife, 328 Law St. Ab, Md.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Hepatorenal Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Post-hepatic cirrhosis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> <u>3 1/2 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-20-1957</u> to <u>12-18-1957</u> that I last saw the deceased alive on <u>12-18-1957</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter P. Rodman</u>				ADDRESS (Street, city or town, state) <u>8 Law St. Aberdeen, Md.</u>			
DATE SIGNED <u>12/21/57</u>							
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12/21/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Carving Aberdeen, Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Mellie R. Perry</u>	

BUREAU V. S.

DEC 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13172 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13170/85

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bridgeport</u> 75X-3	
f. STREET ADDRESS <u>RD 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>Allen</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 3, 1913</u>
9. AGE (in years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NESTER</u>		14. MOTHER'S MAIDEN NAME <u>NO INFORMATION</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No.</u>	
17. INFORMANT <u>Mrs BARBARA HENSLEY</u>		Address <u>CONSHOHOCKEN PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CRUSHING INJURY OF HEAD.</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-bus type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> p. m. <u>12-22-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40 Perryville Cecil Md</u>		20f. (City or town) (County) (State) <u>Perryville Cecil Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>12-22-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 28, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>VALLEY FORGE MEMORIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>UPPER MERION TWP PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pepper's Funeral Home</u>		ADDRESS <u>Donnell St. Bk. City, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. Lewis</u>	

HEAD
I N/Head of

RECEIVED
DEC 30 1957
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13200

CERTIFICATE OF DEATH

Reg. Dist. No.

13171

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>			
c. LENGTH OF STAY IN 1b <u>Entire life</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>H</u> Last <u>Amoss</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-30-1905</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Samuel H. Amoss</u>			
14. MOTHER'S MAIDEN NAME <u>Bora Benson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>278-14-2030</u>				17. INFORMANT <u>Mrs. Rose Amoss</u> Address <u>Fallston Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Coronary Artery Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u> </u> Day <u> </u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that I attended the deceased from <u>March 7</u> , 19 <u>38</u> , to <u>December 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>55</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> No. <u> </u> Forest Hill, Maryland				DATE SIGNED <u>December 9, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>				No. <u> </u> Deputy Medical Examiner <u> </u> County <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>		22d. LOCATION (City, town, or county) <u>Fallston, Hfd Md</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W H Archer - Benson Md</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>12 1957</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH—BIRTH-DEATH-19

1957

BUREAU V. S.

DEC 12 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13172

13173

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>46 Smith Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Madora</u> Last <u>Becker</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23 - 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Strangler</u>				14. MOTHER'S MAIDEN NAME <u>Lauria Robbins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs Glen Bagwell</u> Address <u>46 Smith St</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Thrombocytopenia</u> DUE TO (c) <u>Acute myelogenous leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 hr.</u> <u>6 wk</u> <u>6 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-19-57</u> to <u>12-19-57</u> , that I last saw the deceased alive on <u>12-19-57</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter P. Rodman</u>				ADDRESS (Street, city or town, state) <u>8 Law St. Aberdeen, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>				DATE SIGNED <u>Dec 22-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/22/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Babers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Carney</u> ADDRESS <u>Aberdeen Md</u>				24a. REC'D BY REGISTRAR <u>Dec 22-57</u>		24b. REGISTRAR'S SIGNATURE <u>Thelie R. Perry</u>	

CERTIFICATE OF DEATH

DATE

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

BUREAU V. S.

DEC 26 1957

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13174 CERTIFICATE OF DEATH

13173

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u>		c. LENGTH OF STAY IN 1b <u>18 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>43 HANOVER ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>L.</u> Last <u>BODDY</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>Preston Boddy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Lillie Boddy - Aberdeen, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DECEMBER 13 1957</u> to <u>DECEMBER 14 1957</u> , that I last saw the deceased alive on <u>DECEMBER 13, 1957</u> , and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>569 Revolution St. Harve de Grace, Md. 12/14/57</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		<u>HARVE DE GRACE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Atelis B. Bullock, Harve de Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12-15-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Kemper III.</u>

2000284XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1957

RECEIVED

may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13175 CERTIFICATE OF DEATH

13174
Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVERDE GRACE				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUGENE Middle H Last BOONE				4. DATE OF DEATH Month DECEMBER Day 21 Year 1957			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-8-1888	
9. AGE (In years lost birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jacob Boone			
14. MOTHER'S MAIDEN NAME Leannah Conway				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1911			
16. SOCIAL SECURITY NO. 236-14-9321				17. INFORMANT Mrs. Martha M. Boone - Bel-Air, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary Insufficiency (c) Hypertensive - Arteriosclerotic Heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from June , 19 57 , to Dec. 21 , 19 57 , that I last saw the deceased alive on Dec. 21 , 19 57 , and that death occurred at 5:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George T. Stansbury				A ADDRESS (Street, city or town, state) 529 Revolution St., Harford County, Md.			
PHYSICIAN'S NAME (Type) George T. Stansbury				DATE SIGNED 12/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-57		22c. NAME OF CEMETERY OR CREMATORY Clark's Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Harford County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Bullock - Harford County, Md.				24a. REC'D BY REGISTRAR DATE 12-23-57		24b. REGISTRAR'S SIGNATURE G. L. Lewis m.d.	

FOOTAGE

DEC 12 1941

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13175
187

13176

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Oscar</u> First <u>Bowser</u> Middle <u>Bowser</u> Last				4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1882</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Richard Bowser</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Edith Bowser</u> Address <u>Bel Air R.D. #2 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO lying cause (c) <u>Hypertensive Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12/20</u> , 19 <u>54</u> , to <u>12/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George J. Stansbury</u>				ADDRESS (Street, city or town, state) <u>569 Revolution St., Havre de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				DATE SIGNED <u>12/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mosanna</u>		22d. LOCATION (City, town, or county) (State) <u>Darlington, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Williams</u>				ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 31 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Russell Howard</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 24 1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13177

CERTIFICATE OF DEATH

13176

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural #1 (Stephens)</u>				d. STREET ADDRESS <u>Rural #1 (Stephens)</u>			
3. NAME OF DECEASED (Type or print) <u>Loyd</u> First Middle Last				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/29/1955</u>		9. AGE (In years last birthday) <u>2</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Male Osborne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Morgan Reid Aberdeen #1 sub.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>191X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 19</u> , 19 <u>57</u> , to <u>Dec. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 17</u> , 19 <u>57</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>509 Revolution St., Havre de Grace, Md.</u> DATE SIGNED <u>12/21/57</u>							
ACTUAL SIGNATURE <u>George T. Stansbury</u>				PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrington Aberdeen Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>Dec 23 57</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

RECEIVED

13201 CERTIFICATE OF DEATH

13177

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Chesapeake Gardens Aberdeen, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		d. STREET ADDRESS 402-E Watervaliet St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RICHARD Middle BURKE Last BURKE		4. DATE OF DEATH Month December Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 September 53
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Frankfurt Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lester Burke		14. MOTHER'S MAIDEN NAME Joan I Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Father		Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Concussion Severe DUE TO Conditions, if any, which goys rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Head injury, Laceration spleen, Contusion of left Lung			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile, struck by truck	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 0955 2 Dec 1957		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Route 40		20f. (City or town) (County) (State) Aberdeen Harford Md.	
21. I certify that I attended the deceased from 2 December, 1957 , to 2 December, 1957 , that I last saw the deceased alive on 2 December, 1957 , and that death occurred at 1840p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) US ARMY HOSPITAL ABERDEEN PROVING GROUND, Md. DATE SIGNED 3 December 1957			
ACTUAL SIGNATURE V. G. COSERIU MAJOR MC			
PHYSICIAN'S NAME (Type) V. G. COSERIU MAJOR MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/6/57	22c. NAME OF CEMETERY OR CREMATORY Post Cemetery	22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Lanning		ADDRESS Aberdeen, Md.	24a. REC'D BY REGISTRAR DATE Dec 6/57
		24b. REGISTRAR'S SIGNATURE Hellie R. Perry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DOMINION V. S.

1907

RECEIVED

BUDGET V. S.

DEC 1 1961

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13179

Reg. Dist. No. 82

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norrisville</u> c. LENGTH OF STAY IN 1b <u>-</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Church Road, Highway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norrisville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gladys H. Clark</u> First Middle Last		4. DATE OF DEATH <u>December 14</u> 19 <u>57</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1920</u> 9. AGE (In years last birthday) <u>37</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NORRISVILLE E</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD PRESTON HULSHART</u>		14. MOTHER'S MAIDEN NAME <u>OLIVE E WAILES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>217-16-668</u>	
17. INFORMANT <u>Thomas A. Clarke</u> Address <u>110 LIN HIGH AVE BALTO. MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound, comminuted fracture skull</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4</u> p.m. <u>12-14</u> 19 <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off co bldg., etc.) <u>Church Road Norrisville</u>	20f. (City or town) <u>Norrisville</u> (County) <u>Hartford</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerold C. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerold C. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/17/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NORRISVILLE</u>		22d. LOCATION (City, town, or county) <u>NORRISVILLE</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Furtz</u>		24a. REC'D BY REGISTRAR <u>12-19-57</u>	
ADDRESS <u>Garrettsville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Burilla Howard</u>	

MEDICAL CERTIFICATION

TO THE MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

BUREAU V. S.

DEC 20 1977

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13180

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>216 N. Union Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>E.</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Dublin Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. S. Daugherty</u>		14. MOTHER'S MAIDEN NAME <u>Therese Anna Cantler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>Unknown</u>	
17. INFORMANT <u>Mrs. J. E. Kohler</u>		Address <u>216 N. Union Ave. Harford Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Infarction</u> DUE TO (c) <u>Coronary Arteriosclerosis Embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/13</u> , 19 <u>57</u> , to <u>12/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/16</u> , 19 <u>57</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Wolbert M.D.</u>		ADDRESS (Street, city or town, state) <u>200 North Union Ave. Harford Chase, Md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT M.D.</u>		DATE SIGNED <u>12/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Chase, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funerary Bm. Harford Chase, Md.</u>		24a. REC'D BY REGISTRAR <u>12-19-57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>G. L. Harris M.D.</u>	

BUREAU V. S.

DEC 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13181

CERTIFICATE OF DEATH

Reg. Dist. No.

13181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de Grace, Rt #1</u>		c. LENGTH OF STAY IN 1b <u>23 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Artin Hood Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>L</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/1931</u>
9. AGE (In years last birthday) <u>26</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>3</u> Days <u>22</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Millard Davis</u>		14. MOTHER'S MAIDEN NAME <u>Martha (Roark)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Millard Davis, Artin Hood Road, Harford Co. Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 572X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Nephritis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 10</u> , 19 <u>57</u> , to <u>Dec. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 25</u> , 19 <u>57</u> , and that death occurred at <u>12:15</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gunther D. Hirsch</u>		ADDRESS (Street, city or town, state) <u>421 Congress Ave. HAURE DE GRACE, MD.</u>	
PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u>		DATE SIGNED <u>11/26/57</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/28/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stephen Perry Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William P. Knoch</u>		ADDRESS <u>Chase Md.</u>	
24a. REC'D BY REGISTRAR <u>G. L. Lewis</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 30 1957
BUREAU V. S.

13203 CERTIFICATE OF DEATH

Reg. Dist. No.

187

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>10001 Calvary</u>			
3. NAME OF DECEASED (Type or print) <u>Karren Fay Epperson</u> First Middle Last				4. DATE OF DEATH <u>December 8 1957</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 28, 1957</u>		9. AGE (In years last birthday) <u>7-0-0</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert L. Epperson</u>				14. MOTHER'S MAIDEN NAME <u>Mollie M. Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Albert L. Epperson</u> Address <u>New Castle Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>4900</u> DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO							
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10</u> <u>12-8-57</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-7</u> , 19 <u>57</u> to <u>12-8</u> , 19 <u>57</u> that I last saw the deceased alive on <u>12-7</u> , 19 <u>57</u> , and that death occurred at <u>10A</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>12-8-57</u>			
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epperson Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bluefield, Tazewell, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Williams, Jr.</u> ADDRESS <u>Abingdon, Maryland.</u>				24a. REC'D BY REGISTRAR <u>RECEIVED</u> DATE <u>DEC 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Annella Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 12 19

RECEIVED

13204 CERTIFICATE OF DEATH

13183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fallston</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X1 Fallston</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Friendship Rd.</i>		d. STREET ADDRESS <i>Friendship Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Maurice</i> Middle <i>C.</i> Last <i>Fitch</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>30</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec, 17, 1890</i>
9. AGE (In years last birthday) <i>67</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dispatcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sand & Gravel Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Robert Fitch</i>		14. MOTHER'S MAIDEN NAME <i>Susan Grammer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-28-4034</i>	
17. INFORMANT Address <i>Mrs. Helen P. Fitch, Friendship Rd., Fallston Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 480.1 DUE TO <i>Coronary Sclerotic Heart Dis</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>10 yrs.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchial Asthma, Ch. Alcoholism</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. l. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/17</i> to <i>12/30</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/30</i> , 19 <i>57</i> , and that death occurred at <i>1:45 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Clifford F. Hudson</i>		PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON FORK, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 2, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Zion Evan. Lutheran</i>		22d. LOCATION (City, town, or county) (State) <i>Stemmers Run Balto. Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lissaline Funeral Home</i>		ADDRESS <i>7401 B. Cal. Rd.</i>	
24a. REC'D BY REGISTRAR <i>JAN 3 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Trussell Howard</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13205

CERTIFICATE OF DEATH

13184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1		e. STREET ADDRESS R.D. #1	
3. NAME OF DECEASED (Type or print) First Lena Middle Matilda Last Ford		4. DATE OF DEATH Month December Day 6 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Sept. 1895
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR: Months 6 Days 6 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
11. BIRTHPLACE (State or foreign country) Perryman, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Ford		14. MOTHER'S MAIDEN NAME Sarah Matilda Day Knox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *** **	
17. INFORMANT E. Lawrence Ford		Address Perryman, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Marasmus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Reticular cell sarcoma, retroperitoneal DUE TO (c) 2 1/2 yr.			INTERVAL BETWEEN ONSET AND DEATH 3 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 55 , to 12-6- , 19 57 , that I last saw the deceased alive on 12-5-57 , and that death occurred at 6:50 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter P. Rodman		ADDRESS (Street, city or town, state) 8 Law Street	
PHYSICIAN'S NAME (Type) Peter P. Rodman		M.D. Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/8/57	22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery	22d. LOCATION (City, town, or county) (State) Perryman, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John S. Leasing		ADDRESS Aberdeen, Md.	24. REC'D BY REGISTRAR Dec. 7-57
		25. REGISTRAR'S SIGNATURE Mellie R. Perry	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13206 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13185

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst. tut. on. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Street</u>		c. LENGTH OF STAY IN 1b <u>2 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		e. STREET ADDRESS <u>street</u>	
3. NAME OF DECEASED (Type or print) <u>George F. Frank</u>		4. DATE OF DEATH <u>December 17</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>I</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 28, 1957</u>
9. AGE (In years last birthday) <u>2</u> yrs		10. IF UNDER 1 YEAR <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Tona glia</u>		14. MOTHER'S MAIDEN NAME <u>Sally Franke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Louise Lindberg, 1107 Cavendish</u>		Address <u>no</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Broncho pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>no</u> DUE TO (c) <u>no</u>		INTERVAL BETWEEN ONSET AND DEATH <u>no</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>no</u>		20f. (City or town) (County) (State) <u>no</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>no</u> DATE SIGNED <u>Dec. 17, 1957</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>no</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>no</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 19, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>		ADDRESS <u>no</u>	
24a. REC'D BY REGISTRAR. <u>DEC 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Forwood</u>	

BERNARD V. S.

DEC 17 1977

INT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13182

CERTIFICATE OF DEATH

13186

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green de Grace</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		1d. STREET ADDRESS <u>Box 378 Hoopes Road</u>	
3. NAME OF DECEASED (Type or print) <u>Winnie</u> First <u>L. (Goinos)</u> Middle <u>GOINOS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27/1895</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>John Dudley Reedy</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Mc Shody</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harrison P. Goinos</u>		Address <u>Box 378 Hoopes Rd. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Coronary thrombosis with myocardial infarction</u> DUE TO <u>44-55</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive and arteriosclerotic</u> DUE TO <u>Cardiovascular disease</u> (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec 9th, 1957</u> to <u>Dec 28th, 1957</u> , that I last saw the deceased alive on <u>Dec 28th, 1957</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		DATE SIGNED <u>12/28/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>W.B. Zion Methodist</u>		22d. LOCATION (City, town, or county) <u>Fountain Green, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>Bel Air, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 3 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>	

BUREAU V. S.

JAN 3 1908

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13207

13187
 Reg. Dist. No. 171

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abert-deon</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USA Hosp.</u>				d. STREET ADDRESS <u>RD 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Rutter</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Jan 1907</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George P. Rutter</u>				14. MOTHER'S MAIDEN NAME <u>Margery Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22-0373</u>		Address <u>Charles H. Green, Rising Sun, Md. RD 1.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>					
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-12-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) <u>Port Deposit, Md. Rural</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3 A 1000

2501 1 051

DEALERS

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13208

CERTIFICATE OF DEATH

13188

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kalnia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Jarrettsville	
c. LENGTH OF STAY IN 1b 2 Years		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucretia Middle A Last Harkins		4. DATE OF DEATH Month December Day 20 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months 20 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Harkins		14. MOTHER'S MAIDEN NAME Sarah Machen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Helen Harkins, Bal Air, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure, terminating 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardio-vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 55 to December 20, 19 57 , that I last saw the deceased alive on December 19 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED December 20, 1957			
ACTUAL SIGNATURE Willard P. Hudson, M.D.			
NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 22, 1957	22c. NAME OF CEMETERY OR CREMATORY Brick Baptist Church	22d. LOCATION (City, town, or county) (State) Jarrettsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Hudson, Bal Air, Md.		24a. REC'D BY REGISTRAR DATE 12-22-57	24b. REGISTRAR'S SIGNATURE Priscilla Lowndes

BUNNELL A. E.

DEC. 28 1937

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13189

13209 CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MD</u>		COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>RURAL JOPPA</u>		LENGTH OF STAY (in this place) <u>5 YRS</u>		CITY OR TOWN <u>RURAL JOPPA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location) <u>JOPPA RR #2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ozella</u> (Middle) <u>Marie</u> (Last) <u>Heaps</u>				(Month) <u>12</u> (Day) <u>28</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED; WIDOWED, DIVORCED; (Specify)	8. DATE OF BIRTH <u>1-29-1885</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HARFORD Co., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM WALSH RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH RODGERS WILGIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Frank H. Ziegler Joppa Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
221X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 month.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Essential Hypertension</u>				30 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-27</u> , 19 <u>47</u> , to <u>12-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-27</u> , 19 <u>57</u> , and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Ed O Hordons</u> M.D.				DATE SIGNED <u>12-28-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-31-1957</u>		NAME OF CEMETERY OR-CREMATORY <u>NORRISVILLE METH.</u>		LOCATION (City, town, or county) (State) <u>NORRISVILLE, HARFORD Co., MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Dickerson</u>		ADDRESS <u>Stewartstown Pa</u>	
DATE <u>12-28-57</u>							

RECEIVED

JAN 3 1922

BUREAU W. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13183 CERTIFICATE OF DEATH

13190, ✓
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair		c. LENGTH OF STAY IN 1b 6 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Conv. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adam Middle J. Last Heil		4. DATE OF DEATH Month Dec. Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1866
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 57 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer—Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? US.A.	
13. FATHER'S NAME John Heil		14. MOTHER'S MAIDEN NAME Cecelia Deigelman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William Plummer		Address Rt. 1 Box 140 Joppa, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION (Embolus incident to Auricular fibrillation) DUE TO (b) Chr. Hypertensive cardio-vascular disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 hrs ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0. 01 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov. 10 , 1957 , to Dec. 2 , 1957 , that I last saw the deceased alive on Dec. 1st , 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forrest Hill, Md. DATE SIGNED 12-2-57			
ACTUAL SIGNATURE Willard P. Hudson			
PHYSICIAN'S NAME (Type) WILLARD P. HUDSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-5-1957	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd	24a. REC'D BY REGISTRAR DEC 9 1957
24b. REGISTRAR'S SIGNATURE Thoualla Burrod			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 7 1957

RECEIVED

13184 CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#3 Rogers Street</u>		e. STREET ADDRESS <u>#3 Rogers Street</u>	
3. NAME OF DECEASED (Type or print) <u>Stella Blackwell Johnson</u>		4. DATE OF DEATH <u>12-27-1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/24/1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Blackwell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>E.H. Johnson #3 Rogers St Aberdeen</u>		Address <u>red</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Renal - Uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/2</u> , 19 <u>44</u> to <u>12-28</u> , 19 <u>57</u> that I last saw the deceased alive on <u>12/24</u> , 19 <u>57</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. L. Lewis MD</u>		DATE SIGNED <u>Dec 30 - 57</u>	
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/30/57</u>	<u>North East Cemetery</u>	<u>North East, Cecil Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Herring Aberdeen Md</u>		24a. REC'D BY REGISTRAR <u>Dec 30 - 57</u>	24b. REGISTRAR'S SIGNATURE <u>Willie K Perry</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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141
[unclear]

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13185

CERTIFICATE OF DEATH

13192

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
c. LENGTH OF STAY IN 1b <u>1 hr.</u>		d. STREET ADDRESS <u>Race St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		<input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NOLANES</u> Middle <u>JONES</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1956</u>
9. AGE (In years last birthday) <u>1</u> yrs		IF UNDER 1 YEAR: Months <u>11</u> Days <u>18</u> IF UNDER 24 HRS: Hours <u>11</u> Min <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert H. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Addie E. Griffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Addie E. Jones, Race St, Port Deposit, Md</u>	
17. INFORMANT Address <u>Addie E. Jones, Race St, Port Deposit, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cronchial Pneumonia</u> <u>206.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pertussis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov-12, 1957</u> , to <u>Dec 17, 1957</u> , that I last saw the deceased alive on <u>Dec 17-</u> , 1957, and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence I. Benson</u> M.D.		ADDRESS (Street, city or town, state) <u>Port Deposit Md</u> DATE SIGNED <u>12/19/57</u>	
PHYSICIAN'S NAME (Type) <u>Clarence I. Benson, M.D.</u>		<u>Port Deposit Md</u>	
22a. BURIAL, CREMATION, (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-21-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jones Memorial Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>12-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Hewitt M.D.</u>	

BUREAU V. S.

DEC 28 1957

REC-17710

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13186

CERTIFICATE OF DEATH

13193

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE	
c. LENGTH OF STAY IN 1b LIFETIME		24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE		d. STREET ADDRESS 840 OTSEGO ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLARA HAYES KENNEDY		4. DATE OF DEATH Month Day Year 12 29 1957	
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME FRANKLIN OWENS		14. MOTHER'S MAIDEN NAME MARY M. ANDERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO UNK	
17. INFORMANT FRANKLIN KENNEDY		Address 840 OTSEGO ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Coronary Occlusion DUE TO (b) Chronic Myocarditis DUE TO (c) Chronic Nephritis - Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 200X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 18 19 57 to 12-29 19 57 that I last saw the deceased alive on Dec 29 19 57 and that death occurred at 7:15 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. L. Lewis		DATE SIGNED 12/31/57	
PHYSICIAN'S NAME (Type) A. H. Lewis		ADDRESS (Street, city or town, state) Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/1/58	22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL	22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE MD
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 12-31-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

13210

CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bel Air</u> TOWN <u>Rural Bel Air</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wakefield-Forest Drive</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bel Air</u> TOWN <u>Rural Bel Air</u> STREET ADDRESS (If rural give location) <u>Wakefield-Forest Drive</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Dorothea Bilz Kunkel</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 28 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>August 22, 1887</u>
9. AGE last birthday <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bilz</u>		14. MOTHER'S MAIDEN NAME <u>Barbara BAIER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Mr. John N. Kunkel</u>		<u>Wakefield Forest Drive</u> <u>Bel Air, R.D., Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
1. IMMEDIATE CAUSE (A) <u>CONVULSION & CARDIO RESP FAILURE</u>			<u>5 MINUTES</u>
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBROVASCULAR ACCIDENT</u>			<u>10 MINUTES</u>
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			<u>10 YRS.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>STROKE 3 YRS AGO.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1947</u> , to <u>28 DEC.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 DEC.</u> , 19 <u>57</u> , and that death occurred at <u>10:45 P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>J.P. Adcock</u>		ADDRESS (Street, city, town, state) <u>M.D. 401 Franklin St. Bel Air, Md.</u>	
DATE SIGNED <u>Dec 27</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec. 31, 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR DATE <u>12-30-57</u>		REGISTRAR'S SIGNATURE <u>Priscilla Fowell</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Fater</u>		ADDRESS <u>West Broadway</u> <u>Bel Air, Maryland</u>	

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the Registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13195

13211

CERTIFICATE OF DEATH

Reg. Dist. No. 158

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford Co.</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fallston</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fallston</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Leo</u> (First) <u>LATHROUM</u> (Last)		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1897</u>
9. AGE last birthday <u>60</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leo Jefferson Lathroum</u>		14. MOTHER'S MAIDEN NAME <u>Mary Odie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS <u>Mrs. Mary C. Lathroum</u>		<u>Fallston Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Terminal Arrhythmia or Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Congestive Heart Failure</u>		<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis & Valvular Insufficiency and Cardiomegaly</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept.</u> , 19 <u>57</u> , to <u>Dec.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 20</u> , 19 <u>57</u> , and that death occurred at <u>1:55</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>William A. Tye</u> M.D.		DATE SIGNED <u>12-24-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/27/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem</u>		LOCATION (City, town, or county) (State) <u>Balto.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <u>WIEDEFELD & SON-Greenmount & 22nd</u>		ADDRESS	
DATE <u>12/27/57</u>			

REC 07 1957

RECEIVED
FEB 11 1957

13187 CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>114 N. Union Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Bluma Chonora</u> Middle <u>Keithiser</u> Last		4. DATE OF DEATH <u>12/23/57</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/1879</u>
9. AGE (In years, last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>23</u> Hours <u>57</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Foster</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Jane Knight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>R. H. Luthman</u> <u>114 N. Union Ave.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> DUE TO <u>multiple myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>multiple myeloma</u> DUE TO <u>multiple myeloma</u> (c) <u>multiple myeloma</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 23, 1957</u> to <u>Dec 23, 1957</u> , that I last saw the deceased alive on <u>Dec 23, 1957</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes, and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>12-26-57</u>	
ACTUAL SIGNATURE <u>R. H. Luthman</u> M.D.		PHYSICIAN'S NAME (Type) <u>R. H. Luthman</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James W. Foster</u> ADDRESS <u>114 N. Union Ave.</u>		24a. REC'D BY REGISTRAR <u>G. L. Hewins</u> 24b. REGISTRAR'S SIGNATURE <u>G. L. Hewins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13197
13212 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long Bar</u>		d. STREET ADDRESS <u>Long Bar</u>	
3. NAME OF DECEASED (Type or print) <u>Frank C. Lord</u>		4. DATE OF DEATH <u>December 24</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>Aug. 5, 1887</u>
9. AGE (in years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Munition Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>III</u>		16. SOCIAL SECURITY NO. <u>705-14-0968</u>	
17. INFORMANT <u>Frederick J. Mover</u>		Address <u>Abingdon, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>12-24-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 26, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McBrum</u>		24a. REC'D BY REGISTRAR <u>Dec. 26, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>			

BUREAU V. E.

DEC 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13198

13188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>277 Victory Lane</u>				d. STREET ADDRESS <u>277 Victory Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Joseph</u> Last <u>Loughran</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/16/1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Rep.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hartford Schools</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Loughran</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Merrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Wife - 277 Victory Lane Bel Air Md</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u> </u> 19 <u>55</u> to <u> </u> 19 <u>57</u> that I last saw the deceased alive on <u>Dec 17</u> 19 <u>57</u> , and that death occurred at <u>230 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Ralph Horkey</u> M.D.				ADDRESS (Street, city or town, state) <u>Churchville Md</u>			
PHYSICIAN'S NAME (Type) <u>J. Ralph Horkey MD</u>				DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford County Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garrison</u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>12/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R Perry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1911



may be retained by the hospital attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13189

CERTIFICATE OF DEATH

13199

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Herman Wilson</u> Middle <u>Minnick</u> Last <u>Minnick</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 18, 1905</u>
9. AGE (in years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aberdeen Proving Ground Government Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roy A. Minnick</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Wilgis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-22-0961</u>	
17. INFORMANT <u>Robert Minnick, Bel Air, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO (c) <u>Hypertensive Cardio-vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 1937, to <u>December 4</u> , 1957, that I last saw the deceased alive on <u>December 4</u> , 1957, and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard P. Hydson</u>		ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>December 6, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hydson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>DEC. 7, 1957</u>		22b. DATE THEREOF <u>BURIAL</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DEER CREEK Methodist Cent.</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway, Bel Air, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 12-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Forwood</u>	

MAU V. S.

1901

RECEIVED

13190 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural #2</u>		e. STREET ADDRESS <u>Rural #2</u>	
3. NAME OF DECEASED (Type or print) First <u>Arvie</u> Middle <u>Everist</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>10th</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC.</u>	
13. FATHER'S NAME <u>Geo. E. Everist</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Ann Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Mrs Geo R Jones Aberdeen #2 rural</u>		Address <u>#2 rural</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>4-3</u> 19 <u>37</u> to <u>12/10</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12-10-57</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Havre de Grace, Md.</u> DATE SIGNED <u>12/11/57</u>	
PHYSICIAN'S NAME (Type) <u>A.L. Lewis</u> M.D. <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smiths Chapel</u>	22d. LOCATION (City, town, or county) <u>Aberdeen #2 rural</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Yarrington Aberdeen rural</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>11-57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

DEC 10 1957

RECEIVED

13191. CERTIFICATE OF DEATH

Reg. Dist. No.

18's

1. PLACE OF DEATH a. COUNTY <u>HARRFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARRFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAYRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>50 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 MARKET ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EVALEEN</u> <u>MOORE</u>		4. DATE OF DEATH Month Day Year <u>December</u> <u>18</u> <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 9 1865</u>
9. AGE (In years last birthday) yrs. <u>92</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ALE</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH Waddington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. JENNIE F. HIPPLE, HAYRE DE GRACE, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS - CONGESTIVE H. D.</u> DUE TO (c) <u>OLD AGE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>57</u> , to <u>DEC 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 15</u> , 19 <u>57</u> , and that death occurred at <u>11:15 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>421 CONGRESS AVE. HAYRE DE GRACE, MD.</u> <u>12-20-57</u>			
ACTUAL SIGNATURE <u>Cunther D. Hirsch</u> M.D.		PHYSICIAN'S NAME (Type) <u>CUNTER D. HIRSCH</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>RURAL</u>		22b. DATE THEREOF <u>12-20-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>HAYRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAYRE DE GRACE MD</u>	
24a. REC'D BY REGISTRAR <u>DATE 12-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Lewis m.d.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. M.

DEC 23 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13213

CERTIFICATE OF DEATH

13202

Reg. Dist. No. 151

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MD</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PORT HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>3 WEEKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PORT HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
3. NAME OF DECEASED (First) (Middle) (Last) <u>LILLIE MAY MORRIS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 12 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 7, 1894</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Thomas CURRY</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN A. MOBERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>WILLIAM R MORRIS</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				420.0 IMMEDIATE CAUSE (A) <u>Unlens occlusive heart Disease</u>			
ANTECEDENT CAUSE(S) DUE TO				6 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 30</u> , 19 <u>57</u> , to <u>DEC 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 30</u> , 19 <u>57</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William H. Wadman</u> M.D.				ADDRESS (Street, city, town, state) <u>Harvde Grace MD</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-15-1957</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Run CEM.</u>		LOCATION (City, town, or county) (State) <u>HARFORD Co. MD</u>	
24. REC'D BY REGISTRAR <u>Dec. 17/57</u>		REGISTRAR'S SIGNATURE <u>Lillie M. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison McCall</u>		ADDRESS <u>Harvde Grace MD</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

DEC 20 1967

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13203

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>Baldwin Manor B-6-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		e. IS RELIGIOUS ON A F. P. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nancy Mac Morris</u>		4. DATE OF DEATH <u>December 7 19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5 Sept. 1939</u>
9. AGE (in years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bata Shoe Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Morris</u>		14. MOTHER'S MAIDEN NAME <u>Amy Deckman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-36-9898</u>	
17. INFORMANT <u>Howard Morris</u>		Address <u>Apt. B-6-4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.S.W. R chest</u> <u>919.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Md.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>Man dropped pistol from belt + it fired</u>	
20c. TIME OF INJURY Month, Day, Year <u>Dec 7 19 57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Shamrock Drive Aberdeen Harford</u>		20f. (City or town) (County) (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <u>Beltin, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-8-57</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Southern Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Dublin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Lerring</u>		24a. REC'D BY REGISTRAR <u>Dec 9-57</u>	
ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. L. Lerring</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 12 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13193

CERTIFICATE OF DEATH

13204

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
c. LENGTH OF STAY IN 1b Entire life		d. STREET ADDRESS Bond Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle C Last Orsborn		4. DATE OF DEATH Month December Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1874
9. AGE (In years last birthday) 83 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Enos Rice	
14. MOTHER'S MAIDEN NAME Alice Chancey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hannah Toney, Bel Air, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Chronic Glomerular Nephritis with Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Months 10 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1947 , 19____, to December 18, 1957 , that I last saw the deceased alive on December 18 , 1957, and that death occurred at 10:00 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Forest Hill, Maryland DECEMBER 19, '57			
ACTUAL SIGNATURE Willard P. Hudson M.D.		PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Hendon's Hill	22d. LOCATION (City, town, or county) (State) Bel Air R.D. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		24a. REC'D BY REGISTRAR DATE 12-19-57	
ADDRESS Bel Air, Maryland		24b. REGISTRAR'S SIGNATURE Priscilla Snowdon	

BUREAU A. S.

DEC 20 1941



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13214

CERTIFICATE OF DEATH

13205

Reg. Dist. No. 150

1 PLACE OF DEATH a. COUNTY Harford MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reckord Rd.		d STREET ADDRESS Record Rd.	
3 NAME OF DECEASED (Type or print) First MARY Middle A. Last RUPPERT		4. DATE OF DEATH Month December Day 18 Year 19 57.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1890
9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR: Months 7 Days 18 Hours 18 Min. 57.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kolb		14. MOTHER'S MAIDEN NAME Margaret Eisenreich.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Howard Ruppert		Address Same.	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with decompensation. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 mos. 7 yts.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5 to 12/18 , 19 57 , that I last saw the deceased alive on 12/18 , 19 57 , and that death occurred at 11:10 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Fork, Md. DATE SIGNED	
ACTUAL SIGNATURE Clifford F. Hudson		PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-57.	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer CEM.		22d. LOCATION (City, town, or county) (State) 4430 BELAIR RD. BALTO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler		24a. REC'D BY REGISTRAR 9015 CONKLING ST BALTO., MD.	
24b. REGISTRAR'S SIGNATURE Yasmina Moore		DATE 23 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information for prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13215 CERTIFICATE OF DEATH

13206

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Isaac</u> Middle <u>Slade</u> Last		4. DATE OF DEATH <u>Dec 20</u> - <u>1957</u> Month <u>Dec</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 22 1890</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>28</u> Days <u>28</u> Hours <u>28</u> Min <u>28</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Federal Hill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Ralph Slade</u>		14. MOTHER'S MAIDEN NAME <u>Mary Susan Fletcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>David S. Slade</u> Address <u>Street Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, generalized</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastro-enteritis & Colitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar</u> 1957, to <u>20 Dec</u> 1957, that I last saw the deceased alive on <u>19 Dec</u> 1957, and that death occurred at <u>1 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Tarrettsville, Md.</u> DATE SIGNED <u>Thos. A. E. Moseley, Jr.</u>			
ACTUAL SIGNATURE <u>Thos. A. E. Moseley, Jr.</u> M.D. <u>Tarrettsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Thos. A. E. MOSELEY, JR.</u> <u>Tarrettsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Dec 22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Tarrettsville</u>	22d. LOCATION (City, town, or county) (State) <u>Tarrettsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. E. Slade</u> ADDRESS <u>Tarrettsville</u>		24a. REC'D BY REGISTRAR <u>DATE 2-23-57</u>	24b. REGISTRAR'S SIGNATURE <u>Prucilla Lowwood</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13194

CERTIFICATE OF DEATH

13207

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>607 Bourbon ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MYRTLE Viola Smith</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Arthur A. Preston</u>	
14. MOTHER'S MAIDEN NAME <u>Cecilia Rice</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Pennington Howard Smith</u> Address <u>607 Bourbon ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive G.I. Hemorrhage</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Erosion of paracervical lymphatic vessels</u> DUE TO (c) <u>Acute ulceration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 4, 1957</u> to <u>Dec 27, 1957</u> that I last saw the deceased alive on <u>Dec 27, 1957</u> , and that death occurred at <u>8:45 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm A. Brindley</u> M.D. <u>Harre de Grace</u>		ADDRESS (Street, city or town, state) <u>Harre de Grace, Md.</u> DATE SIGNED <u>12-28-57</u>	
PHYSICIAN'S NAME (Type) <u>Wm A. Brindley</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>12/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>	
22d. LOCATION (City, town, or county) (State) <u>HARREDEGRACE MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington H. Smith</u> ADDRESS <u>Harre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>12-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Harris</u>	



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DEC 30 1957

BUREAU Y. E.

13196

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401-A Watervliet Street				d. STREET ADDRESS 401-A Watervliet Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Susannah Dunsworth Taylor				4. DATE OF DEATH Month Day Year December 12 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 Jan. 1876	
9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Boring				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -- -- --		17. INFORMANT Address Aberdeen, Md. Olin O. Taylor 401-A Watervliet Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Arterio-sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 10, 1957 to Dec 12, 1957 , that I last saw the deceased alive on Dec 12, 1957 , and that death occurred at 2:30 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Andre Weiss MD				ADDRESS (Street, city or town, state) 17 North Phelps Bld		DATE SIGNED 12/13/57	
PHYSICIAN'S NAME (Type) ANDRE WEISS MD				Alendro. Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/14/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Hannibal Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Perry				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE 12-17-57 24b. REGISTRAR'S SIGNATURE William P. Perry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13197

CERTIFICATE OF DEATH

13210

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 17 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				d. STREET ADDRESS 214 S Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET Vinson TRONE				4. DATE OF DEATH Month Day Year DECEMBER 19 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/1926	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWt.		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Vinson				14. MOTHER'S MAIDEN NAME Willard Baker Logan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Dr. J. L. Lane Jr. 214 S Washington Dr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia 4.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 months DUE TO (c) 4 months				INTERVAL BETWEEN ONSET AND DEATH 4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) — (County) — (State) —							
21. I certify that I attended the deceased from Sept. 16th, 1957 to Dec 19th, 1957 that I last saw the deceased alive on Dec 19th, 1957 and that death occurred at 4:25 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave. Haure de Grace, Md.			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				DATE SIGNED 12/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/57		22c. NAME OF CEMETERY OR CREMATORY Bellevue Memorial		22d. LOCATION (City, town, or county) (State) Bellevue, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS —				24a. REC'D BY REGISTRAR —		24b. REGISTRAR'S SIGNATURE —	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13216

CERTIFICATE OF DEATH

13211

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Walton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DeFuniak Springs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital, APG, Md.				d. STREET ADDRESS 304 S. 2nd Street			
3. NAME OF DECEASED (Type or print) First KENNETH Middle DEAN Last WHITTON				4. DATE OF DEATH Month December Day 7 Year 19 57			
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 October 1955		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Charlie M. Whitton				14. MOTHER'S MAIDEN NAME Helen Annett Ruryk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -- -- --		17. INFORMANT Father	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial meningitis, pneumococcic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 December, 1957 , to 7 December, 1957 , that I last saw the deceased alive on 7 December, 1957 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William M. McChene, M.D., USAH, APG, Md. 9 December 1957							
ACTUAL SIGNATURE William M. McChene				PHYSICIAN'S NAME (Type) WILLIAM M. MCCHENER, Capt., MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/10/57		22c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery		22d. LOCATION (City, town, or county) (State) DeFuniak Springs, Fla.	
23. FUNERAL DIRECTOR'S SIGNATURE John D. Loring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Dec. 10 '57	
				24b. REGISTRAR'S SIGNATURE Phillip R. Perry			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13198

CERTIFICATE OF DEATH

13212

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>6 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>200 So. UNION AVE.</u>				STREET ADDRESS (If rural give location) <u>200 So. UNION AVE.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES MAURICE WOLBERT MD.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 3 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 11, 1898</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEDICAL DOCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK MAURICE WOLBERT</u>				14. MOTHER'S MAIDEN NAME <u>CAROLYN C. BURLINGHAM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WORLD WAR #II</u>		17. INFORMANT & ADDRESS <u>DR. FRANK WOLBERT</u> <u>HAVRE DE GRACE MD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Pulmonary Embolism</u>						<u>15 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Phlebotrombosis R. Leg</u>						<u>13 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malignancy of large intestine</u>						<u>1 yr</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1957</u> , to <u>3 Dec., 1957</u> , that I last saw the deceased alive on <u>Dec. 3, 1957</u> , and that death occurred at <u>330 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wallace H. Sadowsky M.D.</u>				ADDRESS (Street, city, town, state) <u>600 S. Union Ave. Havre de Grace, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>DEC. 5, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
24. REC'D BY REGISTRAR DATE <u>12-5-57</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace, Md.</u>	

BONNIE V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

13217 Item 6 Film G221 1-7-58 et

CERTIFICATE OF DEATH

13213

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY USAH APG, HARDFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY HARDFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN PROVING GROUNDS				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAH APG, MD.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 ABERDEEN MARYLAND			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WANE Middle NMI Last WONG				4. DATE OF DEATH Month DEC Day 28 Year 1957			
5. SEX MALE	6. COLOR OR RACE 1/4 Mong.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 DEC 52 (56)	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) ABERDEEN MARYLAND		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME WOTIM WONG				14. MOTHER'S MAIDEN NAME DOMIANA BAROY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Wotim Wong		Address 18 Liberty St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEHYDRATION, ACUTE 571.0 DUE TO VOMITING AND DIARRHEA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO BRONCHOPNEUMONIA (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 DAYS 2 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 27 Dec , 19 57 , to 28 Dec , 19 57 , that I last saw the deceased alive on 28 Dec , 19 57 , and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Charles C. Weise M.D. 303 D Augusta St. Aberdeen, Md. 28 Dec 57 PHYSICIAN'S NAME (Type) CHARLES C. WEISE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/31/57		22c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Cem. of Pacific Honolulu, Hawaii		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Dec 31-57 24b. REGISTRAR'S SIGNATURE Mellie R. Perry	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 3 1938

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

13199

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13214

Item 9 Film G223 12-26-57 et

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Neark	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neark 46 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS 12 Park Lane	
3. NAME OF DECEASED (Type or print) William T. Wright		4. DATE OF DEATH Month December Day 15 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Service Station	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Thomas Wright		14. MOTHER'S MAIDEN NAME Adele Walstrom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subdural hematoma 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12-13-57 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, etc.) Cherry Hill	20f. (City or town) Cecil (County) Md. (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C. Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Ari, Md.	
EXAMINER'S NAME (Type) Gerald C. Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-16-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-19-1957	22c. NAME OF CEMETERY OR CREMATORY Silverbrook	22d. LOCATION (City, town, or county) (State) Wilmington Delaware
23. FUNERAL DIRECTOR'S SIGNATURE Nicholas J. Corleto Wilm., Dela		24a. REC'D BY REGISTRAR Dr. P. L. Lewis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give figures 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 19 1957

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